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No. 90-961

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

ERVIN B. MADDEN,
Petitioner,
vs.
ITT LONG TERM DISABILITY PLAN FOR SALARIED EMPLOYEES; FEDERAL ELECTRIC CORPORATION,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

JOHN L. VIOLA, ESQ.
Counsel of Record
ADAMS, DUQUE & HAZELTINE

523 West Sixth Street
Los Angeles, California 90014
(213) 620-1240

Attorneys for Respondents

Lawyers Brief Service / Legal Printers / (213) 383-4457 / (714) 720-1510

QUESTIONS PRESENTED

1. Should this Court review the question whether, where an ERISA plan expressly gives an administrator or fiduciary discretionary authority to determine eligibility for benefits and authority to delegate such discretionary authority to another fiduciary, and the plan administrator properly delegates such discretionary authority to another fiduciary, the arbitrary and capricious standard of review applies to such other fiduciary, as well as to the plan administrator, under this Court's decision in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989)?

2. Should this Court review the question whether, where an ERISA plan expressly provides for the reduction of plan benefits by Social Security disability insurance benefits, the plan is entitled to recover the retroactive Social Security benefits the plan participant receives for the period he or she also receives plan benefits?*

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* The parent company of respondent Federal Electric Corporation, which was renamed ITT Federal Services Corporation in July, 1990, is ITT Corporation, a publicly held company. All of Federal Electric Corporation's subsidiaries are wholly owned.

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Respondents, the ITT Long Term Disability Plan For Salaried Employees (the "Plan") and Federal Electric Corporation, respectfully request that this Court deny the Petition for Writ of Certiorari seeking review of the Ninth Circuit's decision in this case. That decision is reported at 914 F.2d 1279 (9th Cir. 1990).

STATEMENT OF THE CASE

Respondents do not deem it necessary to set forth detailed corrections to petitioner's Statement of the Case. Rather, for purposes of this Brief in Opposition,

respondents simply rely on the Court of Appeals' statement of the case, *see* 914 F.2d at 1281-1285, and the following brief statement.

1. The Plan Administrator's Discretionary Authority And The Delegation Of That Authority To Metropolitan

The Plan expressly provides ITT Corporation ("ITT"), which is the plan sponsor and the plan administrator, with discretionary authority to determine eligibility for benefits and to construe the terms of the Plan and, further, that such authority may be delegated to an ERISA claims review fiduciary.

Specifically, the Plan provides that the plan administrator:

> Shall have the exclusive right . . . to interpret the Plan and to decide any and all matters arising hereunder, including the right to remedy possible ambiguities, inequities, inconsistencies or omissions . . . . [A]ll interpretations of [the plan administrator] . . . with respect to any matter hereunder shall be final, conclusive and binding on all parties affected thereby. [CR 21, pp. 72-73.]

The Plan also expressly provides, as permitted by ERISA in 29 U.S.C. §§ 1102(a)(2) and 1105(c)(1), that the plan administrator may designate another person as named fiduciary for the full and fair review of claims:

> The [plan administrator] may delegate its authority with respect to the denial,

> granting and administration of claims to a Claims Administrator which may be an insurance company or other appropriate named fiduciary and may enter into a claims administration agreement with such Claims Administrator for the handling and determination of claims, including, but not limited to, the granting or denial of claims and any appeals therefrom. [C.R. 21, pp. 71-72.]

Based on this express authority, ITT, the plan administrator, designated Metropolitan Life Insurance Company ("Metropolitan") as ERISA claims review fiduciary pursuant to a Claims Administration Agreement:

> Upon receipt of a claim, Metropolitan shall review the claim including evaluation by Metropolitan's consultants when required, and determine whether it has been properly filed and the amount, if any, which is due and payable with respect thereto. In making benefit payments, Metropolitan will determine the validity of each claim presented and will, as necessary, make appropriate investigations within the time prescribed for processing claims pursuant to Section 503 of ERISA [(29 U.S.C. § 1133)] . . .
>
> * * *
>
> If benefits are to be wholly or partially denied, Metropolitan shall notify the claimant within a

> reasonable period of time .... Metropolitan will have fiduciary responsibility for provision of full and fair review of claim denials pursuant to Section 503 of ERISA [(29 U.S.C. § 1133)]. Final determination of payment or denial of appealed claims will be made following appropriate analysis and review. [The plan administrator] will promptly submit to Metropolitan any request it receives for a review of a claim for benefits which has been denied, in order that Metropolitan may provide a full and fair review of the claim. [CR 21, p. 93 (Appendix to Petition, pp. 51-52).]

ITT, as the plan administrator, did, however, retain ultimate discretion to construe the terms of the Plan:

> [I]n the event that ITT determines that Metropolitan has misinterpreted the Plan and so informs Metropolitan in writing of such appropriate interpretation, and such interpretation is deemed not unreasonable and not inconsistent with the terms of the Plan to Metropolitan, all claims processed after delivery of such writing to Metropolitan shall be in accordance with the interpretation of ITT, set forth in such writing. [CR 21, pp. 95-96 (Appendix to Petition, p. 53).]

Thus, (1) the Plan expressly gives ITT, the plan administrator, discretionary authority to determine eligibility for benefits and to construe the terms of the Plan, (2) the Plan expressly permits delegation of that

authority to an insurance company as named fiduciary, (3) the delegatee of such authority is to be a named fiduciary with respect to the full and fair review of claims and appeals, (4) the plan administrator in fact delegated such authority to Metropolitan, and (5) Metropolitan served as ERISA claims review fiduciary for the Plan. All of these procedures are authorized by ERISA, which contains detailed provisions allowing for the delegation of fiduciary responsibility to a party who, pursuant to a procedure specified in the plan, then becomes a named fiduciary. *See* 29 U.S.C. §§ 1102(a)(2), 1105(c)(1), 1133.

2. Petitioner's Claim For Plan Benefits And Metropolitan's Review Of His Claim

Petitioner sustained a back injury in 1983, and it is undisputed that he remained totally disabled pursuant to the terms of the Plan and, accordingly, entitled to Plan benefits until 1985. [CR 21, pp. 30-33.] Then, in August 1985, petitioner's attending physician, Dr. Edward A. Smith, upgraded petitioner's condition. Dr. Smith stated that while petitioner was totally disabled from his own job, he was not totally disabled from any other occupation, the Plan's standard of disability in effect at that time. [CR 21, pp. 32-34, 245, 261-262.] Upon review of Dr. Smith's findings and analysis of petitioner's training, education and experience, Metropolitan determined that petitioner no longer qualified for Plan benefits. [CR 21, pp. 34, 232.]

Petitioner then requested a review of Metropolitan's decision. [CR 21, pp. 34, 223-225.] As part of its review, Metropolitan requested petitioner to provide it

with any additional medical information which might aid in review of his claim. [CR 21, pp. 34-35, p. 222.] After four such requests, Metropolitan received detailed information from Dr. Smith confirming his earlier finding of "no total disability" and opining that petitioner had no physical limitations on certain physical activities such as operating electrical equipment, concentrated visual activities, grasping, handling and finger dexterity, activities important in petitioner's occupation in the electronics field.[1] [CR 21, pp. 35-36, 219-221, 332.]

Pursuant to its duties as ERISA claims review fiduciary, Metropolitan reviewed its original decision to terminate Plan benefits. Based on Dr. Smith's findings, Metropolitan affirmed its decision and again invited petitioner to provide it with additional medical information. [CR 21, pp. 36, 216.]

Again, no such information was forthcoming. Instead, petitioner filed a complaint with the State of Washington Department of Insurance. Pursuant to the complaint, Metropolitan conducted a second review of its original decision, again affirming the decision to terminate benefits. [CR 21, pp. 37, 181, 199-201.]

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[1] Petitioner's claim, at page 4, footnote 3 of the Petition, that "[t]he Ninth Circuit's third footnote indicates there was no evidence in the record pertaining to Dr. Jean Michaels' orthopedic evaluation requested by the Social Security Administration" is false. In fact, in that footnote the Ninth Circuit indicated that there was no evidence in the record that Dr. Michaels' evaluation, as well as other medical reports petitioner claims support his claim, was ever forwarded to Metropolitan. Rather, the only medical reports before Metropolitan when it made its decision and reviewed, and re-reviewed and re-re-reviewed that decision, were those of petitioner's attending physician, Dr. Smith. In any event, the "other" reports contain outdated medical information from 1983, 1984 and early 1985, when petitioner admittedly was totally disabled, and, accordingly, are irrelevant.

Petitioner then requested a *third* review of his claim, again providing no additional medical evidence to controvert his attending physician's opinion. Despite the fact that no new evidence was presented, Metropolitan conducted yet a third review, this time utilizing the services of an independent vocational assessment agency. Not surprisingly, in light of the medical evidence, the agency agreed with petitioner's physician and with Metropolitan that petitioner did not meet the Plan's standard of total disability. Metropolitan, therefore, upheld its decision to terminate Plan benefits and petitioner brought this lawsuit. [CR 21, pp. 38, 39, 166, 173, 176-178.]

Importantly, after reviewing the evidence, including the medical evidence which petitioner alleges supports his claim but which evidence he never forwarded to Metropolitan, the District Court held that Metropolitan's decision to terminate Plan benefits to petitioner was correct and must be upheld not only under an arbitrary and capricious standard of review, but even under a *de novo* standard of review. [CR 33, p. 8 (Appendix to Petition, p. 31).]

REASONS WHY THE PETITION SHOULD BE DENIED

The Petition for Writ of Certiorari should be denied.

Although petitioner claims that there is a conflict among the circuits with respect to the first question, in actuality, no conflict exists. Rather, the alleged conflict stems from petitioner's misperception of the undisputed facts in this case. Unlike the facts in the cases petitioner relies on to support the alleged conflict, in this case the Plan at issue expressly provided that ITT, the plan administrator, had discretionary authority to determine

eligibility for benefits and had authority to delegate such discretionary authority to an insurance company to serve as ERISA claims review fiduciary. Further, in this case, the requisite discretionary authority was in fact properly delegated to an insurance company and the insurance company in fact served as the Plan's claims review fiduciary.

Moreover, the Ninth Circuit's decision with respect to the first question was correct and consistent with this Court's holding in *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989) and with ERISA's own provisions which permit a plan to have a procedure under which discretionary authority is delegated to another party, who then becomes a named fiduciary. It makes no sense to permit a plan fiduciary to delegate authority where necessary, but to penalize the plan for such delegation by imposing a more stringent standard of review when it does so.

The second question presented by the Petition not only was decided correctly by the Ninth Circuit, but is not a question of significance worthy of review by this Court because it turns on the specific facts presented by this case. Although this question is important to the parties, there is no public importance associated with its outcome.

I.

THE FIRST QUESTION IS NOT A SOURCE OF CONFLICT AMONG THE CIRCUITS.

The first question presented by the Petition is whether an insurance company's decisions are to be reviewed under an arbitrary and capricious standard of review where the employee benefit plan at issue expressly gives the plan administrator discretionary authority to determine eligibility for benefits and to delegate such authority to another fiduciary, the plan administrator does delegate such authority, and the insurance company, pursuant to such delegation, serves as ERISA claims review fiduciary. Following this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Ninth Circuit held that the arbitrary and capricious standard does apply in these circumstances. Apart from noting the obvious correctness of the Ninth Circuit's resolution of this question, discussed in Part II, hereof, it is respectfully submitted that there is no conflict among the circuits on this issue.

The alleged conflict raised in the Petition allegedly stems from two cases decided by the Eleventh Circuit, *Baker v. Big Star Division of Grand Union Co.*, 893 F.2d 288 (11th Cir. 1989) and *Moon v. American Home Assurance Co.*, 888 F.2d 86 (11th Cir. 1989), and one case decided by a district court, *Buchholz v. General Electric Employee Benefit Plan*, 720 F. Supp. 102 (N.D. Ill. 1989). Petitioner's reliance on these cases as creating a conflict among the circuits, however, is misplaced.

In claiming a conflict among the circuits, petitioner relies on language from these three cases to the effect that where the purely administrative function of initial

claims processing (as distinguished from ERISA's procedure for *review* of claims denials by a named fiduciary, 29 U.S.C. § 1133) has been delegated to an insurance company, the insurance company is not a fiduciary, and, accordingly, its decisions are not subject to the arbitrary and capricious standard of review. *See* Petition at pp. 13-17. Thus, according to petitioner, since Metropolitan allegedly did not serve as claims review fiduciary, the Ninth Circuit's decision is in conflict with the *Baker, Moon,* and *Buchholz* decisions. This conclusion is wrong; an analysis of the undisputed facts reveals that there is no conflict.

First, unlike the instant case, *Baker, Moon,* and *Buchholz* do not involve plans where the plan administrator not only expressly is given discretionary authority to determine eligibility for benefits but also expressly is given authority to delegate that authority to another fiduciary. *See Baker v. Big Star Division of Grand Union Co., supra,* 893 F.2d at 290-92 (court rejected argument that plan fiduciary had "inherent discretionary authority" and, accordingly, that it had "inherent" power to delegate that authority to an insurance company to process claims); *Moon v. American Home Assurance Co., supra,* 888 F.2d at 88-89 (no express grant of discretionary authority to plan administrator and, hence, to insurance company which processed claims); *Buchholz v. General Electric Employee Benefit Plan, supra,* 720 F. Supp. at 103-105 (no discretionary authority to determine eligibility for benefits provided by terms of plan).

Second, both the District Court and the Ninth Circuit found that Metropolitan served as ERISA claims review fiduciary.[2] Moreover, an analysis of the relevant facts

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[2] Because both the District Court and the Court of Appeals found that Metropolitan served as claims review fiduciary, application of

(continued)

indicates that the Courts' determination of this factual issue was correct.

ERISA defines a "fiduciary" as one who

> exercises any discretionary authority or discretionary control respecting management of [a] plan or exercises any authority or control respecting management or disposition of its assets . . . or has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A)(i). Pursuant to ERISA, a claims review fiduciary shall afford "a full and fair review" of any decision denying a claim for benefits. 29 U.S.C. § 1133(2); 29 C.F.R. § 2560.503-1(g)(1) (employee benefit plans must establish procedures by which denied claims may be appealed to "an appropriate named fiduciary . . . and under which a full and fair review of the claim and its denial may be obtained"). Moreover, under ERISA, a named fiduciary may delegate its fiduciary responsibilities to other persons:

> The instrument under which a plan is maintained may expressly provide for procedures . . . (B) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than

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(ftn. continued)
the "two court rule" precludes review by this Court "in the absence of a very obvious and exceptional showing of error." *Graver Tank & Mfg. Co. v. Linde Air Products Co.*, 336 U.S. 271, 275 (1949). Petitioner has made no such showing here.

> trustee responsibilities) under the plan.

29 U.S.C. § 1105(c)(1); *see also* 29 U.S.C. § 1102(a)(2).

Here, as noted above, ITT, the plan administrator, not only is given the discretionary authority to construe the terms of the Plan and determine eligibility for benefits, but also is given the express authority to *delegate* that authority. Pursuant to such authority, ITT delegated to Metropolitan its discretionary authority to determine eligibility for benefits and review denied claims. Metropolitan, in turn, agreed to provide the full and fair review of claims and to serve as ERISA claims review fiduciary and, in fact, did so.

Although petitioner claims that ITT did no more than "rent" Metropolitan's claim department and, accordingly, that Metropolitan did not serve as a fiduciary, *see* Petition at pp. 11, 20-23, this contention is belied by the undisputed facts.

Unlike the case in the *Baker, Moon,* and *Buchholz* cases relied on by petitioner, Metropolitan did more than perform the initial determination of petitioner's claim. Rather, pursuant to its express grant of authority, upon petitioner's appeal of its decision terminating payment of Plan benefits, Metropolitan, acting in its capacity as ERISA claims review fiduciary, reviewed, re-reviewed and re-re-reviewed its initial decision. And, in performing its review, Metropolitan had the full discretion to determine petitioner's claim. Thus, unlike the insurance company/claims administrators in *Baker, Moon,* and *Buchholz,* Metropolitan served as ERISA claims review fiduciary.

Accordingly, the perceived conflict among the circuits is an illusory one based upon petitioner's misperception of the undisputed facts.

II.

THE NINTH CIRCUIT'S RULING ON THE FIRST QUESTION IS CORRECT AND IS CONSISTENT WITH THIS COURT'S DECISION IN *FIRESTONE TIRE & RUBBER CO. v. BRUCH* AND THE PROVISIONS OF ERISA.

Even assuming, for the sake of argument, that in fact there is a conflict among the circuits on the first question — and, as discussed above, there is not — the Ninth Circuit's decision on the first question was correct and consistent with this Court's decision in *Firestone Tire & Rubber Co. v. Bruch, supra,* and the provisions of ERISA.

In *Firestone* this Court ruled that

> a denial of benefits challenged under [29 U.S.C.] § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.

Firestone Tire & Rubber Co. v. Bruch, supra, 489 U.S. at 115.

Here, as discussed above, under the terms of the Plan, ITT, which served as plan administrator, was given, and in turn delegated to Metropolitan, discretionary authority "to determine eligibility for benefits or to construe the terms of the plan." It would thwart the clear intent of Congress and make no sense to hold that where a plan

administrator is given the requisite discretionary authority pursuant to *Firestone* and is also given by the plan the power to delegate such discretionary authority to another fiduciary, pursuant to statute, *see* 29 U.S.C. §§ 1105(c)(1), 1102(a)(2), and 1133, that one standard of review, the arbitrary and capricious standard, applies to the plan administrator but another standard of review, the *de novo* standard, applies to the insurance company/ claims review fiduciary to which such discretionary authority is delegated.

If plan decisions were to be accorded a greater or lesser degree of deference depending on whether plan fiduciaries delegated their authority to other persons, this would have the effect of discouraging delegation of authority to experts where such delegation is proper. Congress, in providing in ERISA for procedures for the delegation of fiduciary duties, plainly encouraged the use of experts. Indeed, it is submitted that it may be a breach of a fiduciary's responsibility *not* to delegate the requisite authority in specialized areas, such as disability claims reviews, where the fiduciary does not possess the requisite expertise to fulfill its responsibility to the plan and to plan participants and beneficiaries.

There simply is no logical reason why, where the plan administrator/named fiduciary is expressly given discretionary authority and properly delegates that discretionary authority to another fiduciary, the named fiduciary to which the authority is delegated should not be accorded the same degree of deference in its decision making as is the plan administrator/named fiduciary. The Ninth Circuit's decision, therefore, is correct and is consistent with this Court's decision in *Firestone Tire & Rubber Co. v. Bruch, supra,* as well as the provisions of ERISA.

III.

THE SECOND QUESTION DOES NOT PRESENT AN ISSUE OF GENERAL IMPORTANCE.

The second question presented by the Petition is whether, where an ERISA plan provides for the reduction of plan benefits by Social Security disability insurance benefits, the plan is entitled to recover the retroactive Social Security benefits the plan participant receives for the period he or she also receives plan benefits.[3]

This question is not of sufficient importance to warrant review by this Court under Supreme Court Rule 10(c). Rather, this issue is fact specific, involving a construction of the terms of the Plan as reflected by the summary plan description. Both the District Court and the Ninth Circuit found that the Plan provides for a reduction of Plan benefits by the amount of Social Security disability insurance benefits paid to a Plan participant and that this reduction is clearly set forth in the summary plan description. Petitioner, however, in effect claims that because the Social Security Administration incorrectly denied his claim for benefits at first, only later reversing itself and awarding retroactive benefits *after* the Plan had begun paying Plan benefits to him, that he therefore is entitled to keep the retroactive Social Security benefits.

This claim defies logic. The Plan clearly provides, and petitioner admits, that payable Plan benefits are to be reduced by Social Security benefits. No limitation is

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[3] Petitioner's assertion that the Plan filed its Counterclaim seeking reimbursement of the retroactive Social Security benefits only after it filed its motion for summary judgment is wrong.

placed on the time at which the Social Security benefits are paid. Rather, the terms of the Plan require a reduction of Plan benefits for Social Security benefits payable for the same period regardless of when the Social Security benefits are actually paid. Were petitioner permitted to keep the Social Security benefits, the terms of the Plan would be violated and petitioner would be unjustly enriched, at the expense of the Plan and other Plan participants, due solely to the Social Security Administration's delay in awarding benefits. Petitioner would receive a windfall at the expense of the other Plan participants. Thus, not surprisingly, petitioner's argument was rejected by the Ninth Circuit, and other courts which have faced this issue have rejected similar arguments. *See Stuart v. Metropolitan Life Ins. Co.*, 664 F. Supp. 619 (D. Me. 1987), *aff'd*, 849 F.2d 1534 (1st Cir.), *cert. denied*, 488 U.S. 968 (1988); *Poisson v. Allstate Life Ins. Co.*, 640 F. Supp. 147 (D. Me. 1986); *Barklage v. Metropolitan Life Ins. Co.*, 614 F. Supp. 51 (W.D. Mo. 1985); *Henning v. Metropolitan Life Ins. Co.*, 546 F. Supp. 442 (M.D. Pa. 1982).

CONCLUSION

The Petition for Writ of Certiorari in this case presents questions which are of limited significance because they were resolved against petitioner by both courts below based upon the particular facts of the case. When these facts are analyzed, it is clear that there is no split among the circuits on the first question and that this question was correctly decided by the Ninth Circuit on the facts of this case, and that the second question similarly depends solely on the applicable facts. For these reasons, the Petition should be denied.

Respectfully submitted,

JOHN L. VIOLA, ESQ.
Counsel of Record

ADAMS DUQUE & HAZELTINE

Attorneys for Respondents

APPENDIX A

STATUTES, REGULATIONS AND RULES

29 U.S.C. § 1102. Establishment of plan

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(2) For purposes of this subchapter, the term "named fiduciary" means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly . . . .

29 U.S.C. § 1105. Liability for breach of co-fiduciary

* * *

(c) Allocation of fiduciary responsibility; designated persons to carry out fiduciary responsibilities

(1) The instrument under which a plan is maintained may expressly provide for procedures (A) for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries, and (B) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan . . .

29 U.S.C. § 1133. Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall —

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 C.F.R. § 2560.503-1 Claims procedure . . .

(g) *Review procedure.* (1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

Supreme Court Rule 10. Considerations Governing Review on Writ of Certiorari

.1 A review on writ of certiorari is not a matter of right, but of judicial discretion. A petition for a writ of certiorari will be granted only when there are special and important reasons therefor. The following, while neither controlling nor fully measuring the Court's discretion, indicate the character of reasons that will be considered:

. . .

(c) When a state court or a United States court of appeals has decided an important question of federal law which has not been, but should be, settled by this Court, or has decided a federal question in a way that conflicts with applicable decisions of this Court.